RCW 48.44.010 Definitions. For the purposes of this chapter:

(1) "Carrier" means a health maintenance organization, an insurer, a health care service contractor, or other entity responsible for the payment of benefits or provision of services under a group or individual contract.

(2) "Census date" means the date upon which a health care services contractor offering coverage to a small employer must base rate calculations. For a small employer applying for a health benefit plan through a contractor other than its current contractor, the census date is the date that final group composition is received by the contractor. For a small employer that is renewing its health benefit plan through its existing contractor, the census date is ninety days prior to the effective date of the renewal.

(3) "Commissioner" means the insurance commissioner.

(4) "Copayment" means an amount specified in a group or individual contract which is an obligation of an enrolled participant for a specific service which is not fully prepaid.

(5) "Deductible" means the amount an enrolled participant is responsible to pay before the health care service contractor begins to pay the costs associated with treatment.

(6) "Enrolled participant" means a person or group of persons who have entered into a contractual arrangement or on whose behalf a contractual arrangement has been entered into with a health care service contractor to receive health care services.

(7) "Fully subordinated debt" means those debts that meet the requirements of RCW 48.44.037(3) and are recorded as equity.

(8) "Group contract" means a contract for health care services which by its terms limits eligibility to members of a specific group. The group contract may include coverage for dependents.

(9) "Health care service contractor" means any corporation, cooperative group, or association, which is sponsored by or otherwise intimately connected with a provider or group of providers, who or which not otherwise being engaged in the insurance business, accepts prepayment for health care services from or for the benefit of persons or groups of persons as consideration for providing such persons with any health care services. "Health care service contractor" does not include direct patient-provider primary care practices as defined in RCW 48.150.010.

(10) "Health care services" means and includes medical, surgical, dental, chiropractic, hospital, optometric, podiatric, pharmaceutical, ambulance, custodial, mental health, and other therapeutic services.

(11) "Individual contract" means a contract for health care services issued to and covering an individual. An individual contract may include dependents.

(12) "Insolvent" or "insolvency" means that the organization has been declared insolvent and is placed under an order of liquidation by a court of competent jurisdiction.

(13) "Net worth" means the excess of total admitted assets as defined in RCW 48.12.010 over total liabilities but the liabilities shall not include fully subordinated debt.

(14) "Participating provider" means a provider, who or which has contracted in writing with a health care service contractor to accept payment from and to look solely to such contractor according to the terms of the subscriber contract for any health care services rendered to a person who has previously paid, or on whose behalf prepayment has been made, to such contractor for such services.

(15) "Provider" means any health professional, hospital, or other institution, organization, or person that furnishes health care services and is licensed to furnish such services.

(16) "Replacement coverage" means the benefits provided by a succeeding carrier.

(17) "Uncovered expenditures" means the costs to the health care service contractor for health care services that are the obligation of the health care service contractor for which an enrolled participant would also be liable in the event of the health care service contractor's insolvency and for which no alternative arrangements have been made as provided herein. The term does not include expenditures for covered services when a provider has agreed not to bill the enrolled participant even though the provider is not paid by the health care service contractor, or for services that are guaranteed, insured or assumed by a person or organization other than the health care service contractor. [2010 c 292 § 3; 2007 c 267 § 2; 1990 c 120 § 1; 1986 c 223 § 1. Prior: 1983 c 286 § 3; 1983 c 154 § 3; 1980 c 102 § 10; 1965 c 87 § 1; 1961 c 197 § 1; 1947 c 268 § 1; Rem. Supp. 1947 § 6131-10.]

Reviser's note: The definitions in this section have been alphabetized pursuant to RCW 1.08.015(2)(k).

Application—2010 c 292: See note following RCW 48.43.005.

Severability—1983 c 286: See note following RCW 48.44.309.

Severability—1983 c 154: See note following RCW 48.44.299.